RESEARCH PLAN PROPOSAL

PSYCHO-SOCIAL CONCOMITANTS OF COPING BEHAVIOUR: A STUDY OF MOTHERS OF MENTALLY CHALLENGED CHILDREN

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"The more I read and the more I talked to other parents of children with disabilities and normal children, the more I found that feelings and emotions about children are very much the same in all families. The accident of illness or disability serves only to intensify feelings and emotions, not to change them."

Judith Weatherly

INTRODUCTION

MENTAL RETARDATION:

The American psychiatric association (1994) in DSM IV defines mental retardation as "significantly sub-average general intellectual functioning..... that is accompanied by significant limitation in adaptive functioning" (p.39) in certain skill areas such as self-care, work, health and safety.
It is recognized in ICD 10 at F70-F79.
Mental retardation is a developmental disability in which the intellectual ability and adaptive behaviour of an individual becomes deficient to a sub average level. According to this definition an individual to be regarded mentally retarded must fulfil at least 3 conditions.

1) The individual must have below average intellectual ability. According to the American association of mental deficiency (AAMD), the individuals IQ must be below 70 on the Wechsler scale.
2) There must be a significant impairment in the adaptive behaviour of the individual must demonstrate an inability to meet the standard of personal and social responsibilities appropriate to his/her age group.
3) These, deficiencies in intellectual functioning and adaptive behaviour must occur during the developmental period of the individual. In other words, they must show for the first time before the age of 18 years.

These criteria thus exclude individuals who become in capacitated intellectually or socially in adulthood as a result of brain injuries or other disease from being called mentally retarded.

Classification of mental retardation:

Mental retardation is classified by different methods. They are psychological and educational classification. Psychological classification is based on the level of intelligence and educational classification is based on the current level of functioning of the mentally retarded person/child.

PSYCHOLOGICAL CLASSIFICATION

The following ranges, based on Standard Scores of intelligence tests, reflect the categories of the American Association of Mental Retardation, the Diagnostic and Statistical Manual of Mental Disorders-IV-TR, and the International Classification of Diseases-10.

CLASS	IQ	CHILDREN REQUIRE	FORMALLY CALLED
Mild mental retardation	50–55 to 70	mild support	"Educable Mentally Retarded".
Moderate retardation	35–40 to 50–55	moderate supervision	"Trainable Mentally Retarded".
Severe mental retardation	20–25 to 35–40	Can be taught basic life skills and simple tasks with supervision.	
Profound mental retardation	IQ below 20–25	Usually caused by a neurological condition; require constant care.	Custodial

The DSM-IV diagnosis of mental retardation is further specified with a code or grouping label that indicates the diagnosing clinician's impression of the severity of the presenting retardation. This grouping label is linked to IQ.

a) Mild Mental Retardation affects 85 percent of the mentally retarded population. Their IQ score ranges from 50-75. Many individuals within this group can achieve academic success at about the sixth grade level. They can become self-sufficient and in some cases, live independently with community and social support.

b) Moderate Mental Retardation affects around 10 percent of the individuals under the classification of mental retardation. This group score between 35 and 55 on IQ tests and has adequate communication skills. Many of these individuals function very well in group homes and in the community. Many are employed and can take care of themselves with minimal supervision

c) Severe Mental Retardation describes 3 - 4 percent of the population within this classification. IQ scores range from 20 to 40. Communication skills and self-help skills are very basic and many individuals require supervision and assistance. Many of these individuals reside in group homes with assistance.

d) Profound Mental Retardation describes a very small portion of the mentally retarded population, about 1 - 2 percent of those affected. These individuals score under 25 on IQ tests and require around-the-clock care and support. Their communication skills are limited and they require assistance for self-care. People with profound mental retardation usually have neurological disorders as well.

MENTAL RETARDATION on DSM IV Axis II.
317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified

EDUCATIONAL CLASSIFICATION

Educators classify mental retarded children as educable mentally retarded (EMR), trainable mentally retarded (TMR), and severely and profound handicapped (SPH).

a) Educable mentally retarded (EMR) individuals are those who possess IQs between 75-70 and 50. More and more school system is now using 70, whereas previously they used 75.
b) Trainable mentally retarded (TMR) individuals are those who possess IQs between 50 and 25.
c) Severely and profound handicapped (SPH) individuals are those who possess IQs below 25.

The various classifications provide an understanding of the levels at which the mentally retarded person function with respect to his education, appropriate behaviour and the degree of his independence.

EDUCABLE MENTALLYRETARDED (EMR):

The educable are those with IQ between 50-75. Their mental growth, when they become adults, roughly corresponds to normal children of age 8 to 12 years of age. Their school achievement will be, therefore, low, somewhere between 4 to 8 classes. They will however, be able to receive many kinds of occupational training and lead fairly independent and useful life economically and socially. They will be able to live a happy and successful life with a little supervision and understanding. There will be a number of such people living contented lives without being noticed as mentally retarded, particularly in rural areas, doing many semi-skilled works. Current terminology for educable mentally retarded includes Mild Mentally Handicapped.

Role of significant others in the life of mentally retarded children:

Accepting a child with mental retardation becomes difficult for parents and the whole family particularly when competence and achievement are very much valued in modern world. Thus when it

suddenly becomes necessary for parents to love someone who has a very limited capacity the parents are put in conflicting situations and result in a great deal of stress.

The birth and continuing care of mentally retarded children are often stressful experiences for family members as these children's difficulties inevitably touch the lives of those around them. (Cronic, Friedrich, Greenberg, 1983 and Featherstone, 1980).

Mental handicap forms a significant problem affecting the lives of mentally handicapped individuals and their families. The nature of mental handicap is, "arrested or delayed development", which means, that there is both a limited level of functioning, as well as, need for additional supports from the family and community over long period of life.

There is no doubt, to believe that having a mentally handicap in the family, calls for a lot of adjustment on the part of parents and other family members. The impact of such a child on family may be so great that parents may often require considerable time and help in order to achieve an emotional acceptance of the child and the handicap.

Experience of having a mentally retarded child:

The birth of a child whether disable or non-disable is known to produce pressure since it includes adjustments and extra responsibilities for various members of the family. However, birth of a mentally retarded child does produce greater pressure on the family because of extra demands of child care, greater financial burden and above all that the child worry and tension that the child is not normal.

Chance of experiencing positive effects because of having mentally retarded child:

Families where parents prior to having a mentally retarded child had a good relationship i.e. had a strong relationship of caring and sharing tend to come even closer to each other to face the situation of having a mentally retarded child. Some parents report having more patience and humanistic attitude.

Brothers and sisters of mentally retarded individual may choose to take up professions which are of helping nature, develop more humanity, become more considerate, concerned, cooperative and tolerant in their dealing with others.

Common emotional reactions that parents go through:

On knowing that the child is mentally retarded and shall not be able to recover from the condition fully, the hope of parents get shattered, it is quite a normal reaction to such a situation. Different parents may react differently. Some may initially experience shock or disbelief, that their child could be mentally retarded, some may deny and hope that everything will be alright after some time; some may get angry and blame self or others for such conditions. Some parents may get extremely upset, depressed and nothing may seem important to them anymore. These reactions may not stay permanently; it is also not necessary that all parents must pass through these emotional outbursts.

Some parents take longer than others to adjust with the situation whereby they start taking constructive steps to face the reality and do their best to help train their mentally retarded child. Some parents are able to understand their own feelings, analyses their own problems and adjust faster hence, may require minimal help from the professionals vice versa may also occur. The earlier these feelings overcome the better it is because if they continue to stay longer it can affect the health adjustments within the family, cause detrimental effect on the physical and mental health of the parents. This could lead to undue delay in initiating or carrying out the right training programmes for the mentally retarded child and may also interfere in health parent's professional relationship. A study done by Cleveland (1980),and Lamb (1983), Morgan el al., pointed out that fathers and mothers may react differently to the retarded child- the mother may take on the role of physical protector and guardian of the child's need while the father is more reserved in his role. He may cope by withdrawing, internalizing his feelings.

Impact on mother:

Some mothers are able to cope up better with the situation of having mentally retarded child than the others. However mothers are generally known to face maximum stress and pressure because of owing the major responsibilities of bringing up the child. Mothers are more affected by the stress and strain of caring for the child. They face various problems and their coping is disturbed. This disturbed coping has a serious consequence for the mentally retarded child as well as the family and society (Turnbull et al., 1984) Fathers generally do not make a bigger contribution than they would in ordinary families hence mother continue to struggle between meeting the household work and child's special needs. If the mother happens to be a working lady she has to put up with much greater pressure. Stress in known to be higher in mothers than in fathers of handicapped children. Mothers are a greater risk of developing stress related illness such as migraine, body aches and pains, hypertension, anxiety and depression.

Effect of mentally retarded child on the family:

Each child is unique in this world so is each family, having its own strengths and weaknesses to face the challenges from time to time. Most of the parents and other family members naturally do start worrying about the future of the children with mental retardation, feel sad or depressed at various stages of child's life, the social life of the family gets affected, they may like to keep themselves aloof from others and indulge less in recreational or leisure activities.AyeleGebremariam (1993) pointed out that a retarded child is a heavy loading on the stability and aspirations both of the parents and siblings. Some families face rejection or neglect from the family members, friends or relatives and hence the interpersonal relationships gets strained leading to loss of support. Some generally, the mothers particularly give up their jobs leading to greater financial strains, fathers may seek jobs or transfers at places where services for such children are available. The effect however vary from family to family depending upon the quality and quantity of emotional, financial and physical support available, degree

of child's handicap and his age and whether the child has additional problems such as physical disability or behaviour problems.Researchers have noted that birth of retarded child shatters the hope and aspirations of parents leading to hopelessness and negative attitude towards the child (Ramaswamy, 1995).

Factors that helped families having mentally retarded member in better adjustment:

Indian parents reported that major things found most useful in coping up with the situation of having a mentally retarded child includes getting physical help for looking after the mentally retarded child especially by the spouse/husband or grandparents.Heiman (2002) reported that support from others is another important factor helping parents to cope better. Other things found useful includes acceptance of the mentally retarded child especially by the parental grandparents, financial help, early and timely advice provided by the professionals and their empathetic attitude.

VARIABLES OF THE STUDY

a) Spirituality:

Peterson and Seligman (2004) observed that spirituality is universal: "Although the specific content of spiritual beliefs varies, all cultures have a concept of an ultimate, transcendent, sacred, and divine force".

Pargament and Mahoney (2002) Spirituality represents the key and unique function of religion. Spirituality is defined as a search for the sacred.....People can take a virtually limitless number of pathways in their attempts to discover and conserve the sacred.....Pathways involve systems of belief that include those of traditional organized religions (e.g., Protestant, Roman Catholic, Jewish, Hindu, Buddhist, Muslim), newer spirituality movements (e.g., feminist, goddess, ecological, spiritualities) and more individualized worldviews

b) Happiness:

Happiness is commonly understood as how much one likes the life one lives, or more formally, the degree to which one evaluates one's life-as-a-whole positively (Veenhoven 2004)

Fordyce 1972 states "Happiness is a particular emotion. It is an overall evaluation made by the individual in accounting all his pleasant and unpleasant experiences in the recent past."

c) Resilience:

"Resilience" stems from the Latin *resilire* and means to "rebound" (oxford dictionary, 1989). Resilience is viewed as an outcome that enables individuals to survive or even thrive in the

midst of adversity, and incorporates hardiness as an internal trait (Cannor, Davidson & Lee, 2003)

Resilience in psychology is the positive capacity of people to cope with stress and adversity. Resilience is most commonly understood as a process, and not a trait of an individual.

d) Social support:

The physical and psychological comfort provided by other people (Sarason, Sarason, & Pierce, 1994)

Also is beneficial in times of stress, and it is effective regardless of the Kind of coping strategies that are used (Frazier et al., 2000)

e) Coping strategies:

Coping refers to the way in which people deal with threats and with their emotional consequences (Taylor, Tunnen et al., 2000)

Coping strategy refers to a technique of coping adopted in a specific context.

Coping strategies are thoughts and behaviors that are used to manage or cope with stressful situations.

REVIEW OF LITERATURE

COPING STRATEGIES IN MOTHERS OF MENTALLY RETARDED CHILDREN

- In a study done by Kim, H.W. in 1999 to compare the coping processes between aging mothers of adults with mental illness versus aging mothers of adults with mental retardation pointed out that Mothers of mentally challenged use more of problem focused coping.
- Blair, C.T. (2003) found out that mothers use more of religious coping. In their study to see the use of religious coping in parents who have a child with mental retardation.
- In 2008 a study was conducted byUpadhyaya&Havalappanavar to study the various coping strategies used by the parents of mentally challenged. Fathers and mothers of 628 mentally challenged individuals were assessed. Results indicated that mothers most commonly used coping strategies are problem solving, religious-faith and denial-blame. They use more problem focused coping than emotional focused.

SOCIAL SUPPORTIN MOTHERS OF MENTALLY RETARDED CHILDREN

- Psychosocial assets of parents of handicapped and non-handicapped children were studied by Friedrich & Friedrich in 1981 the differences between mothers of mentally handicapped and non-handicapped children were studied. The results indicated that mothers of handicapped children reported less social support then mothers of non-handicapped Children.
- Peshawaria R, etal. (2000) conducted a research to study the facilitators and inhibitors of coping by parents who have children with mental retardation. The results indicated that Mothers reported external supports provided by others as a greater facilitator than their internal coping skills.
- Edgar A. Doll, (2006) reported that the ability of a mother of an intellectually disable child to cope is related to the available social support. In her study which aimed at counseling the mentally retarded and their parents.

RESILIENCE IN MOTHERS OF MENTALLY RETARDED CHILDREN

- In a recent study conducted by Gerstein et al., 2010 to study Resilience and the course of daily parenting stress in families of young children with intellectual disabilities they reported that the factors leading to resilient fathers and mothers are not fully similar. Although individual parent characteristics and high-quality dyadic relationships contribute to emerging resilience in parents of child in these families.

METHODOLOGY

RATIONALE OF THE STUDY:

The birth of a child with developmental or intellectual disability can impose additionalPhysical, financial and emotional demands on the parents than children without disability. Research indicates that parents of children with disability appear to experience higher levels of stress and depression than other parents (Beckman, 1983; Beckman-Bell, 1981;Hadadian, 1994; Hanson and Hanline, 1990; Holroyd and McArthur, 1976; Kazakand Marvin, 1984; Scott *et al.*, 1989), and that disruptions to the family life cycle arelikely to occur (Hanline, 1991).

Perhaps because dysfunctional families are particularly noticeable in medical settings,much of the literature on families with children with disability has approachedfamily stress from a deficit model (Kazak and Marvin, 1984). Thus,professionals often hold a negative and pessimistic view of families with childrenwith disability (Knussen and Sloper, 1992; Singer and Powers, 1993). The medicaldeficit model emphasises that a child with disability adversely affects the familysystem; he/she will tend to create more burdens in care giving and financial expenses,as well as unbalance the family dynamic and add to marital strains. Theseparents and families need professional assistance and advice to raise their disabledchild and "cure" problems once and for all (Singer and Powers, 1993).

In their well intentioned efforts to document areas of difficulty in families with children with disability, researchers have sometimes neglected to describe ways in which differences may indicate successful family functioning within a different but not "deviant" family structure (Kazak and Marvin) .Successful, adaptive functioning offamilies with children with disability has not received sufficient attention.

One should not automatically assume that the family is under debilitating stress when they have a child with disability. Some families have been able to adapt and cope successfully and keep stress conditions under manageable control (Gallagher *et al.,* 1981). In fact, there is a growing body of knowledge which indicates that the presence of a family member with a disability may contribute to the strengthening of the entire familyunit, as well as contribute positively to the quality of life of individual members of thefamily (e.g. Summers *et al.,* 1989; Wikler*et al.,* 1983; Winzer, 1990).

A family's ability to adapt to a crisis situation is influenced by the family's use of personal resources such as the parents' psychological strengths, and by family resources such as the extent of family unity or integration (McCubbin and Patterson, 1983). Recovery from a crisis seems also depending upon the family's social resources, e.g., the helpful intervention of friends and social services. And lastly, the family's definition of the crisis event influences its adaptation to the crisis event.

Relating these factors to families with members with disability, it is logical to assume that participation in a parent support group and strong personal faith and religiousaffiliation are important to the adjustment and adaptation of parents of childrenwith intellectual disability. Moreover it is very likely that families with children withintellectual disability that have adequate crisis-meeting resources will have less stress,greater family harmony, and a stronger feeling of personal reward associated withparenting . In sum, spousal support, participation in a parents' group, and religious beliefs should prove to be important resources used to cope with the challengesof rearing a disabled child.

This viewis in keeping with the latest paradigm shift in psychology which focuses more on the positive aspects of human existence and functioning. It can also have far reaching consequences for family support interventions that mental health professionals may plan for parents and children from such background. As opposed to the negative view of coping in parents with intellectually challenged children this view advocates thatprofessionals need to establish a spirit of partnership and collaboration in working with families of disabled children towards a common goal. All families have their own strengths, and when problems are identified in a family they can be given the opportunity to acquire skills and resources so family members can learn to solve their problems.

A review of literature shows that there is an acute paucity of research studies which focus on the positive correlates of coping in mothers of intellectually challenged children not only in Indian but also International context .Therefore, it occurred to the present investigator to fill in these lacuna and to take up a fresh study on coping in mothers of educable mentally challenged children with respect to spirituality, happiness, resilience and social support.

AIMS AND OBJECTIVES:

- To compare mothers of educable mentally retarded and normal children on the measures of the study viz, spirituality, happiness, resilience and social support.
- To compare the mothers with high and low coping abilities on the four measures of the study.
- To assess the joint influence of the two independent variables of the study on happiness, resilience, spirituality and social support.

HYPOTHESES:

- The two groups of mothers will differ significantly on the measures of happiness, spirituality, resilience and social support.
- There will be a significant effect of type of coping (high and low) on thefour measures of the study.
- There will be an interactional effect of the independent variables on the dependent measures of the study viz, spirituality, happiness, resilience and social support.

SAMPLE OF THE STUDY:

The sample size of the study will be 100. The participants will be mothers of educable mentally retarded children (between the age group of 7 to 15 years) studying in special schools and mothers of normal children (between the age group of 7 to 15 years) studying in regular schools.

The detail of the sample is as given below:

Mothers of EMR	Mothers of normal children	Total
50	50	100

Inclusion criteria:

1. Subjects aged between 30 to 45 years.
2. Subjects conversant with English language.
3. Subjects who areat least college graduates.
4. Subjects in the upper and middle income groups.
5. Subjects staying in nuclear families.

Exclusion criteria:

1. Subjects suffering from any psychiatric illness.
2. Subject diagnosed with mental or physical disability.
3. Subjects from joint families.
4. Subject who are single parent.
5. Subjects with a single child.
6. Subjects with more than one child with mental/physical handicap.

In the present study simple random sampling will be used.

DESIGN OF THE STUDY:

The study will be conducted based on 2X 2 Factorial Design.

2 groups / Level of coping	Mothers of EMR	Mothers of normal children
Mothers with High coping ability	25	25
Mothers with Low coping ability	25	25
	50	50

Total- 100

PROCEDURE:

The study will be conducted in two phases. In the Ist phase based on the criteria of inclusion and exclusion a list of mothers with educable mentally retarded children studying in various special schools and mothers of normal children studying in regular schools in the city of Jaipur will be made from the prepared lists 50 mothers in each of the two groups will be randomly selected.

In the IIndphase after obtaining consent from the subjects, psychological tools of the study will be administered.

TOOLS OF THE STUDY:

1. Spiritual Assessment Inventory (SAI)(Hall & Edwards,1996)

The Spiritual Assessment Inventory (SAI) was developed to address thepsychometric and theoretical limitations that seemed to exist in other instruments(MacDonald, Kuentzel& Freidman, 1999). Hall and Edwards (1996) sought to developand instrument to measure spiritual maturity that could be used by "pastoral counsellorsand clinicians working with religiously-oriented clients".The theoretical base for the SAI is derived from the idea that "spiritual maturityfrom both biblical and psychological perspectives involves, at its core, relationship withCognitive-Spiritual others. Object relations theory provides a cogent framework within which to articulate this aspect of spirituality" (Hall& Edwards, 1996, p. 236). The psychometric measure of the instrument has been addressed through factor analytic studies (Hall & Edwards, 1996, 2002).Tisdale's (1999) review of the SAI indicated that the inventory was constructedon the idea that spiritual maturity is composed of two specific dimensions: the degree ofawareness by an individual of God in his or her life and the quality of that relationship.Hall and Edwards (1996) note that these dimensions should be related, but distinct. Theyadd, a person can be quite developed in being aware of God's voice without relating toHim in a mature way. Likewise, an individual can be mature in the way he or sherelates to God, without having a very developed capacity to be aware of God'svoice.

There are five scales used in the SAI. They include:

- Awareness: a measure of the extent to which a person is aware of God in his or her life. A high score indicate the presence of this trait.
- Realistic Acceptance: a measure of the level of a person's ability to experience and tolerate mixed feelings regarding ones relationship to God. A high score would indicate the ability to have negative experiences and still maintain confidence in God's care of them. People tend to reach this stage in late adolescence or early adult years.
- Grandiosity: A measure of relating with an inflated sense of self importance and uniqueness. High scores would indicate the presence of Cognitive-Spiritual this trait. People tend to reach this stage of spiritual maturity in the middle years of childhood.

- Instability: A measure of relating in an expression of all-good or all-bad views of self and others. A high score on this scale would indicate the presence of that trait. People tend to reach this stage of spiritual maturity as a young child.
- Disappointment: A scale that functions similar to a Lie Scale. A low score on this measure suggests that the test taker is being defensive regarding his or her actual spiritual life and thus would raise the validity of the other responses.

The test itself can be taken in about fifteen minutes. It uses a 5-point Likert format with 1 indicating no endorsement and 5 indicating endorsement of the statement. The instrument is for use with college adults.

Reliability.

The Spiritual Assessment Inventory's (SAI) reliability for the five factors using Cronback's coefficient alpha measure of internal consistency reported .88 for Instability, .91 for Defensiveness; .90 for Awareness; .76 for Acceptance and .52 for Grandiosity. Cognitive-Spiritual MacDonald, Kuentzel and Freidman (1999) stated that the, "Examination of thepsychometric properties of the SAI factors generated largely supportive results".

Validity.

The Construct validity is based on results of factor analysis completed by Hall and Edwards (1996, 2002) and Hall, Brokaw, Edwards and Pike (1998). There is limited research history since it is a relatively new scale. Results indicated a positive outlook with the exception of the Grandiosity scale which is undergoing further investigation (Tisdale, 1999).

2. Oxford Happiness Inventory (Angyle, Martin &Crossland 1989)

The oxford happiness inventory (Argyle, et al., 1989) is a 29 item multiple choice instrument which provides a general measure of happiness. They supposed that happiness depended on frequency and positive effect, or joy, high level of satisfaction over a period of time, and the absence of negative feeling such as depression or anxiety.

Angyle, Martin and Crossland(1989) reported an internal reliability of .90 using Cronbach's alpha, and a 7 week test-retest reliability of .78. Construct validity was developed, based on three hypothesized components of happiness: the correlation between the oxford happiness inventory and positive affect scale as measured by the Bradburn Balanced Affect Scale (Bradburn,1963) was .32. the correlation between the oxford happiness inventory and Argyl's Life Satisfaction Index (Argyle,1987) was .57, and the correlation between the oxford happiness inventory and beck depression inventory (Beck,1978) was .-52. Each item of the scale contains 6 options, constructed to reflect incremental steps defined as: strongly disagree to strongly agree. The respondents will be asked to pick out the one option in each statement which best describes the way you have been feeling over the past week including today.

3. Connor-Davidson Resilience Scale (Connor & Davidson, 2003)

The CD-RISC is a self-report measure aimed at adults and older adolescents. As described the authors (2003), "Resilience may be viewed as a measure of stress coping ability and, as such, could be an important target of treatment in anxiety, depression and stress reactions. TheCD-RISC is comprised of 25 items, each rated on a 5-point scale, with higher scores reflecting greater resilience. The scale has been administered in several studies to group in the community, primary care outpatients, general psychiatric outpatients, a clinical trial of generalized anxiety disorder, and two clinical trials of PTSD. The scale demonstrated good psychometric properties and factor analysis yielded five factors. A repeated-measure ANOVA showed that an increase in CD-RISC score was associated with greater improvement in treatment for those with PTSD."

It demonstrates good internal consistency at test1-test2 with cronbach's alpha's being 0.87 and 0.85, respectively. Alpha reliability was observed as for factor1,<=0.80, factor2,<=0.75,factor3, <=0.74, factor4, <=0.69, and overall <=0.89. the 5 factors are- factor 1 = personal competence, factor 2- self-trust tolerance, factor 3= positive acceptance, factor 4 = control and factor 5 = spiritual influence.

4. Social Support Appraisal Scale (SS-A)(Vaux, Phillips, Holley, Thompson, Williams & Stewart, 1986)

The Social Support Appraisals Scale (SS-A Vaux, Phillips, Holley, Thompson, Williams, & Stewart, 1986.) is a 23-item instrument based on "the idea that social support is in fact support only if the individual believes it is available" (Corcoran & Fischer, 1987). The items are rated on a likert scale from 1-4.a score of 1 denotes "strongly agree" and 4 indicate "strongly disagree." Higher overall scores imply a low evaluation of perceived social support. On the other hand, lower overall scores imply a high evaluation of perceived social support.

The SSA has good concurrent, predictive, known-groups, and constructs validity. It also has good internal reliability (alpha coefficients ranging from .81 to .90 (Corcoran & Fischer, 1987). concurrent validity is significantly related to a variety of measures of social support and psychological well-being Good concurrent, predictive, known-groups, and construct validity.

5. Coping Response Inventory – Adult form (Rudolf H. Moos, 1992)

The coping response inventory is composed of eight subscales that measure different types of coping responses to stressful life circumstances.

The first two subscales in each set reflect cognitive coping strategies and the third and fourth subscales in each set reflect behavioural coping strategies.

APPROACH COPING RESPONSES

1- Logical Analysis (LA)

2- Positive reappraisal (PR)

3- Seeking support and information (GS)

4- Taking problem solving action (PS)

AVOIDANCE COPING RESPONSES

5- Cognitive Avoidance (CA)

6- Acceptance or resignation (RA)

7- Seeking alternative rewards (AR)

8- Emotional Discharge (ED)

Each of these eight dimensions of subscales is composed of six items. Respondents select a recent (focal) stressor and rate their reliance on each of the 48 coping items on a 4 point scale, varying from "not at all (0)" to "fairly often (3)"

These are treated as raw scores which can be interpreted as norms with the help of the manual. The inventory also includes a set of 10 items that measure how respondents appraise the focal stressor and its outcome.

STATISTICAL ANALYSIS:

1. Mean
2. Standard deviation
3. F-test

SPSS 16 will be used to analyse the data.

LIMITATIONS OF THE STUDY

1. Due to the nature of the study the sample size is limited.
2. Only objective test are used.
3. Role of gender in coping behaviour of caregiver in case of educable mentally retarded children should also be taken into consideration

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APPENDIX

APPENDIX - A

SPIRITUAL ASSESSMENT INVENTORY

Todd W. Hall, Ph.D. & Keith J. Edwards, Ph.D.

Instructions

1. Please respond to each statement by ticking the option that best represents your experience.
2. It is best to answer according to what really reflects your experiences rather than what you think your experience should be.
3. Give the answer that comes to your mind first. Don't spend too much time thinking about an item.
4. Give the best possible response to each of the statement even if it does not provide all the information you would like.
5. Try your best to respond to all statements. Your answers will be completely confidential.
6. Some of the statements consist of two parts.

S.NO	STATEMENT	NOT AT ALL TRUE	SLIGHTLY TRUE	MODERATELY TRUE	SUBSTANTIALLY TRUE	VERY TRUE
1	I have a sense of how god is working in my life					
2.1	There are times when I feel disappointed with god					
2.2	When this happens, I still want our relationship to continue					
3	God's presence feels very real to me					
4	I am afraid that god will give up on me					
5	I seem to have a unique ability to influence god through my prayers					
6	Listening to god is an essential part of my life					
7	I am always in a worshipful mood when I go to church					
8.1	There are times when I feel frustrated with god					
8.2	When I feel this way, I still desire to put effort into our relationship					
9	I am aware of god prompting me to do things					
10	My emotional connection with god is unstable					
11	My experience of god's					

	responses to me impact me greatly					
12.1	There are times when I feel irritated at god					
12.2	When I feel this way, i am able to come to some sense of resolution in our relationship					
13	God recognizes that I am more spiritual than most people					
14	I always seek god's guidance for every decision I make					
15	I am aware of god's presence in my interactions with other people					
16	There are times when I feel that god is punishing me					
17	I am aware of god responding to me in a variety of ways					
18.1	There are times when I feel angry at god					
18.2	When this happens, I still have the sense that god will always be with me					
19	I am aware of god attending to me in times of need					
20	God understands that my needs are more important than most people's					
21	I am aware of god telling me to do something					
22	I worry that I will be left out of god's plans					
23	My experiences of god's presence impacts me greatly					
24	I am always as kind at home as I am at church					
25	I have a sense of the direction in which god is guiding me					
26	My relationship with god is an extraordinary one that most people would not understand					
27.1	There are times when I feel betrayed by god					
27.2	When I feel this way, I put effort into restoring our relationship					
28	I am aware of god communicating to me in a variety of ways					
29	Manipulating god seems to be the best way to get what I want					

30	I am aware of god's presence in times of need					
31	From day to day, I sense god being with me					
32	I pray for all my friends and relatives every day					
33.1	There are times when I feel frustrated by god for not responding to my prayers					
33.2	When I feel this way, I am able to talk it through with god					
34	I have a sense of god communicating guidance to me					
35	When I sin, I tend to withdraw from god					
36	I experience an awareness of god speaking to me personally					
37	I find my prayers to god are more effective than other people's					
38	I am always in the mood to pray.					
39	I feel I have to please god or he might reject me					
40	I have a strong impression of god's presence					
41	There are times when I feel that god is angry at me					
42	I am aware of god being very near to me					
43	When I sin, I am afraid of what god will do to me					
44	When i consult god about decisions in my life, I am aware to my prayers of his directions and help					
45	I seem to be more gifted than most people in discerning god's will					
46	When I feel god is not protecting me, I tend to feel worthless					
47.1	There are times when I feel like god has let me down					
47.2	When this happens, my trust in god is not completely broken					

APPENDIX B

OXFORD HAPPINESS INVENTORY

Angyle, Martin and Crossland(1989)

Instructions: Below are a number of statements about happiness. Please indicate how much you agree or disagree with each by entering a number in the blank after each Statement, according to the following scale:

1 = strongly disagree

2 = moderately disagree

3 = slightly disagree

4 = slightly agree

5 = moderately agree

6 = strongly agree

Please read the statements carefully, because some are phrased positively and othersnegatively. Don't take too long over individual questions; there are no "right" or "wrong"answers (and no trick questions). The first answer that comes into your head is probablythe right one for you. If you find some of the questions difficult, please give the answerthat is true for you in general or for most of the time.

The Questionnaire:

1. I don't feel particularly pleased with the way I am. ()_____

2. I am intensely interested in other people._____

3. I feel that life is very rewarding._____

4. I have very warm feelings towards almost everyone._____

5. I rarely wake up feeling rested. ()_____

6. I am not particularly optimistic about the future. ()_____

7. I find most things amusing._____

8. I am always committed and involved._____

9. Life is good._____

10. I do not think that the world is a good place. ()_____

11. I laugh a lot._____

12. I am well satisfied about everything in my life._____

13. I don't think I look attractive. ()_____

14. There is a gap between what I would like to do and what I have done. ()_____

15. I am very happy._____

16. I find beauty in some things._____

17. I always have a cheerful effect on others._____

18. I can fit in (find time for) everything I want to._____

19. I feel that I am not especially in control of my life. ()_____
20. I feel able to take anything on._____
21. I feel fully mentally alert._____
22. I often experience joy and elation._____
23. I don’t find it easy to make decisions. ()_____
24. I don’t have a particular sense of meaning and purpose in my life. ()_____
25. I feel I have a great deal of energy._____
26. I usually have a good influence on events._____
27. I don’t have fun with other people. ()_____
28. I don’t feel particularly healthy. ()_____
29. I don’t have particularly happy memories of the past. ()_____

APPENDIX C

CONNOR-DAVIDSON RESILIENCE SCALE (2003)

Below is a list of statements please mark a cross (*) in the box u agree with. There are 5 options for each statement ranging from “not at all true” to “nearly always true”.

S.NO	CD-RISC ITEM	NOT AT ALL TRUE	RARELY TRUE	SOMETIMES TRUE	OFTEN TRUE	NEARLY ALWAYS TRUE
1	I am able to adopt to change					
2	I form close and secure relationships					
3	Sometimes fate or god can help					
4	I can deal with whatever comes					
5	Past success gives me confidence for new challenges					
6	I see the humorous side of things					
7	Coping with stress strengthens					
8	I tend to bounce back after illness or hardship					
9	Things happen for a reason					
10	I make the best effort, no matter what					
11	I can achieve my goals					
12	When things look hopeless i don’t give up					
13	I know where to turn for help					
14	Under pressure, i am able to focus and think clearly					
15	I prefer to take the lead in problem-solving					
16	I am not easily discouraged by failure					
17	I think of myself as strong person					
18	I sometimes have to make unpopular or difficult decisions					
19	I can handle unpleasant feelings					
20	I am able to act on a hunch					
21	I have a strong sense of purpose					
22	I am in control of my life					
23	I like challenges					
24	I work to attain my goals					
25	I take pride in my achievements					

APPENDIX D

SOCIAL SUPPORT APPRAISALS

Vaux, Phillips,Holley, Thompson, Williams, & Stewart, 1986

Below are a list of statements about your relationships with family and friends. Please indicate how much you agree or disagree with each statement as being true.

S. NO	STATEMENTS	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1	My friends respect me	1	2	3	4
2	My family cares for me very much	1	2	3	4
3	I am not important to others	1	2	3	4
4	My family holds me in high esteem	1	2	3	4
5	I am well liked	1	2	3	4
6	I can rely on my friends	1	2	3	4
7	I am really admired by my family	1	2	3	4
8	I am respected by other people	1	2	3	4
9	I am loved dearly by my family	1	2	3	4
10	My friends don't care about my welfare	1	2	3	4
11	Members of my family rely on me	1	2	3	4
12	I am held in high esteem	1	2	3	4
13	I can't rely on my family for support	1	2	3	4
14	People admire me	1	2	3	4
15	I feel a strong bond with my friends	1	2	3	4
16	My friends look out for me	1	2	3	4
17	I feel valued by other people	1	2	3	4
18	My family really respects me	1	2	3	4
19	My friends and i are really important to each other	1	2	3	4
20	I feel like i belong	1	2	3	4
21	If i died tomorrow, very few people would miss me	1	2	3	4
22	I don't feel close to members of my family	1	2	3	4
23	My friends and i have done a lot for one another	1	2	3	4

APPENDIX E

MOOS COPING INVENTORY

RUDOLF H. MOOS, 1992

DEALING WITH A PROBLEM OF SITUATION

Please think about the most important problem of stressful situation you have experienced IN THE LAST 12 MONTHS (for example, having troubles with a relative of friend, experiencing the illness of death of a relative of friend having an accident of illness, having financial or work problems.). Describe the problem in the space provided below. If you have not experienced a major problem, then list a minor problem that you have had to deal with.

DESCRIBE THE PROBLEM OR SITUATUON:

Part – I

Please answer the following questions about the problem or situation place an "X" in the appropriate box:

		Definitely No 1	Mainly No 2	Mainly Yes 3	Definitely Yes 4
1.	Have you ever faced a problem like this before?				
2.	Did you know this problem was going to occur?				
3.	Did you have enough time to get ready to handle this problem?				
4.	When this problem occurred did you think of it as a threat?				
5.	When this problem occurred did you think of it as a challenge?				
6.	Was this problem caused by something you did?				
7.	Was this problem caused by something someone else did?				
8.	Did anything good come out of dealing with this problem?				
9.	Has this problem of situation been resolved				
10.	If the problem has been worked out, did it turn out all right for you?				

Part – II

Please think about the problem you described on page 2 and then tell us which of the following you did in connection with the problem. Place an "X" in the box that shows us what you did. :

	DID YOU	NO	YES ONCE OF TWICE	YES SOMETIMES	YES FAIRLY OFTEN
1	Think of different ways to deal with the problem				
2	Tell yourself things to make yourself feel fetter				
3	Talk with your spouse or other relative about the problem				
4	Make a plan of action and follow it				
5	Try to forget the whole thing				
6	feel that time would make a difference the only thing to do was wait				
7	Try to help others deal with a similar problem				
8	Take it out on other people when you felt angry of depressed				
9	Try to step back from the situation and be more objectives				
10	Remind yourself how much worse things could be				
11	talk with a friend about the problem				
12	Know what had to be done and try hard to make things work				
13	try not to think about the problem				
14	realize that you had no control over the problem				
15	get involved in new activities				
16	take a chance and do something risky				
17	Go over in your mind what you would say or do				
18	Try to see the good side of the situation				
19	Talk with a professional person (e.g., doctor, lawyer, clergy)				
20	Decide what you wanted and try hard to get it				
21	Daydream or imagine a better time or place than the one you were in				
22	Think that the outcome would be decided by fate				
23	Try to make new friends				
24	keep away from people in general				

25	Try to anticipate how things would turn out				
26	Think about how you were much better off than other people with similar problems				
27	Seek help from persons of groups with the same type of problem				
28	Try at least two different way to solve the problem				
29	Try to put off thinking about the situation, even though you knew you would have to at some point				
30	Accept it nothing could be done				
31	Read more often as a source of enjoyment				
32	yell or shout to let off steam				
33	try to find some personal meaning in the situation				
34	Try to tell yourself that things would get better				
35	Try to find out more about the situation				
36	Try to learn to do more things on your own				
37	Wish the problem would go away of somehow be over with				
38	Expect the worst possible outcome				
39	Spend more time in recreational activities				
40	Cry to let your feelings out				
41	Try to anticipate the new demands that would be placed on you				
42	Think about how this event would change your life in a positive way				
43	pray for guidance and/or strength				
44	Take things a day at a time one step at a time				
45	Try to deny how serious the problem really was				
46	lose hope that things would ever be the same				
47	Turn to work or other activities to help you manage things				
48	Do something that you didn’t think would work, but at least you were doing something				